TESTIMONY BEFORE
KANSAS HEALTH POLICY AUTHORITY
JULY 13, 2006

Executive Director Nielson and members of the Health Policy Authority, my name is Sam Serrill. I am Chief Operating Officer of Wesley Medical Center, located in Wichita, Kansas. As a representative of Wesley Medical Center I would like to commend the Health Policy Board for conducting these stakeholder meetings throughout the State as part of your very important responsibility to develop health policy for our citizenry.

One of your major tasks is to conduct a review and study of the issues relating to Specialty Hospitals and the Kansas Hospital Licensure Law, and prepare recommendations concerning this matter. It is this subject that I am addressing today.

The current Kansas Hospital Licensure Law needs to be revised. This law has not been updated in years and should be modernized to reflect changes in hospital care and treatment in the past 40 years.

The licensure law should require that medical care facilities determine whether they are going to be general hospitals, limited service facilities, or some other type of facility. Hospitals wanting to be general hospitals must provide services consistent with the responsibilities of general hospitals, including provisions for a dedicated emergency department that operates 24 hours of every day, provide diagnosis and treatment for patients with a variety of medical conditions as opposed to selected diagnoses, participate

in the delivery of emergency medical services applicable to its region and is a participating provider in the Kansas Medicaid program.

Currently there are medical care facilities that want to enjoy the privileges of general hospitals, but don't want to incur the costs that accompany the responsibilities required of general hospitals. These facilities selectively admit patients based on acuity and insurance type, cherry-picking the most profitable patients and services. They avoid the costs associated with care and treatment of patients with lower reimbursement rates, complicated procedures that require basic inherent risks that threaten profitability, care and treatment for uninsured or underinsured individuals, and care and treatment that is less profitable, all of which are left to be provided by the community general hospitals.

In many communities, like Wichita, some physicians are exploiting a loophole in federal law, and own limited-service "hospitals" to which they refer their own patients. This activity raises serious concerns about conflict of interest, fair competition, and whether the best interests of both patients and their communities are being served, or abused.

Since 1997 there has been a 364% increase in the number of limited service facilities – and it is important to make the distinction clear. These are not full service hospitals open to the general public with emergency rooms, labor and delivery rooms, and many other services provided by true community hospitals. They are simply single specialty surgery centers focused on a narrow range of the most profitable services (cardiology, surgery, orthopedics) offered to an even narrower group of low risk, well insured patients.

Due to a well-documented pattern of over utilization and abuse, Congress enacted prohibitions in 1989 and 1993 to prevent physicians from referring their patients to facilities they or their family members own. As part of these laws, the "whole hospital" exception was also created. This exception is the loophole that is being exploited in Wichita by the Kansas Heart Hospital, Galichia Heart Hospital, Kansas Spine Hospital and Kansas Surgery and Recovery Center. Physician owned limited service facilities have been shown by the Government Accountability Office, MedPAC, McManis Consulting and the Lewin Group to select the least sick and most profitable patients, provide little or no emergency services, increase utilization and costs, and damage full service community hospitals leading to cutbacks in services. The impact at Wesley Medical Center with the proliferation of limited service hospitals has included a reduction in hospital financial performance, a corresponding reduction in staff through lay offs,

and elimination of programs including occupational medicine, electron microscopy research center and pharmacy research program. At the same time our labor costs have increased in areas like cardiology services in order to compete for the limited supply of qualified health care workers.

When these physician owned entities open, several things happen almost immediately: physician owners redirect their patients; physician owners make huge profits – 30 to 35% margin in their first year; and community hospitals suffer financially, bearing all the burden for Medicaid and uninsured patients, with fewer resources to serve the community and subsidize essential, yet unprofitable services. For example, net revenues for Wesley Medical Center's heart program decreased by $16 million after the Galichia Heart Hospital opened in 2001. Similarly, net revenues in Wesley's neurosurgery program dropped #8.5 million after the opening of the Kansas Spine Hospital in 2003.

Physician owners "double-dip" by getting paid for the procedures they perform and for their investment. The net profit to physician investors for their referrals can be $5,000 profit per referral. Community hospitals can be convicted of fraud if the value of non-monetary compensation to a physician exceeds $322 per year or is in any way related to their referrals. If it is unethical and illegal for physicians to own and refer to their own laboratories, x-ray centers, and a host of other services, how can it be legal for them to refer to their own hospitals? The

answer is simple – it shouldn't be. But the loophole has to be closed and the self-referral laws have to be enforced.

In January 2005, the MedPAC commissioners unanimously voted to extend the federal moratorium on specialty hospitals until January 1, 2007. In 2005, the Kansas Hospital Association introduced legislation as a safety valve to temporarily hold the development of any new hospitals in Kansas for one year. This moratorium would have given the Kansas legislature time to study the impacts of this burgeoning trend on Kansas and decide whether it is good or not for our citizens and state. That legislation did not pass at the state level, despite the Senate passing a resolution memorializing Congress to extend the moratorium, and the problem facing Kansas continues.

One last comment before closing, Kansas has adopted as part of its Manual on Uniform Traffic Control Devices, the Blue H, so common on our nations highways. Kansas requires that a hospital have 1) 24-hour service, 7 days a week; 2) Emergency department facilities with a physician (or emergency care nurse on with duty within the emergency department with a physician on call) trained in emergency medical procedures on duty; 3) be licensed for definitive medical care by the appropriate state authority; and 4) be equipped for radio voice communications with ambulances and other hospitals. This is another example of the state expecting a certain standard of care from our community hospitals.

For our state to set reasonable expectations of general hospitals is appropriate, and it is time that Kansas licensure laws reflect these responsibilities.

Further proliferation of limited service facilities will lead to increased utilization and costs, unfair competition, and damaging consequences to the safety net of community hospitals, which serve our state.

For competition to be effective, it has to be fair (a “level playing field”), and it has to be free from conflicts of interest.

I urge you to study carefully the issues related to specialty hospitals and the Kansas Hospital Licensure Law as you perform your role in establishing important health policy for this state.

Thank you for the opportunity to present our position on this matter with you today. I will be happy to address any questions you have.

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